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Recovery grows up

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Introduction

Recovery has come of age. The recovery approach has gained traction in mental health policy throughout the English-speaking world, and - at least rhetorically - within mental health systems internationally (Slade, Amering and Oades 2008). But with age comes responsibility. An idea can initiate change, but that change must work in practice if it is to be sustained.

This special issue on recovery marks a shift from ideology to empirical investigation. The studies report data addressing important questions. We begin by identifying some ideological statements made by recovery proponents, and reviewing recent evidence relating to these beliefs. We then consider some of the scientific challenges in investigating recovery.

‘Recovery is a process, not just an outcome’

A valid understanding of recovery must be grounded in lived experience. Todd and colleagues (this issue) explore the meaning of recovery for people with bipolar disorder, adding to a growing evidence base on self-management in this group (Jones et al. 2011). Their findings make clear that the key dimensions of personal recovery differ from traditional clinical preoccupations.

To clarify what personal recovery means, a systematic review was undertaken to collate and synthesise published frameworks and models of recovery (Leamy et al. 2011). A total of 97 papers from thirteen different countries which offered new conceptualisations of recovery were identified. The types of papers included qualitative studies, narrative literature reviews, book chapters, consultation documents reporting the use of consensus methods, opinion pieces, editorials, quantitative studies, as well as papers which combined different methods. Empirical studies recruited participants from a range of settings including community mental health teams and facilities, self help groups, consumer-operated mental health services and supported housing facilities. The majority of studies used inclusion criteria that covered any diagnosis of severe mental illness.

A modified narrative synthesis of these papers showed that recovery can be thought of (a) as a journey which varies from one person to another, (b) as inter-linking sets of processes, and (c) can also be understood through the application of social cognition models of how the recovery journey itself varies over time and within individuals. The narrative synthesis identified thirteen characteristics of the recovery journey, five over-arching recovery processes comprising Connectedness, Hope and optimism about the future, Identity, Meaning in life and Empowerment (giving the acronym CHIME) and thirteen stage models of recovery. The synthesis is applicable across cultures (Slade et al. in press).

The CHIME recovery processes provide an empirically-based theoretical underpinning for (a) recovery-oriented research, (b) mental health professionals to inform clinical interventions, and (c) health service managers, to inform

organisational policies, such as recruiting staff that hold pro-recovery values and attitudes. Relating to managers, Lakeman found experts by experience (*i.e.* people using mental health services) agreed on the importance of recovery competencies, such as the ability of staff to inspire hope in service users that recovery is possible, or to be able to empower a person to draw upon their own strengths and personal resources to aid their recovery (Lakeman 2010).

‘Recovery begins when you find someone or something to relate to’

Yates and colleagues (this issue) investigate the under-researched relationship between location and recovery. More generally, if recovery differs across settings, then research is needed with different communities. Kartalova-O’Doherty and colleagues (this issue) investigate recovery experiences in Ireland.

Recent research has also focussed on experiences of people from minority populations. Although, there is a growing literature defining and conceptualising recovery, it has predominantly been based on research with majority populations. For example, O’Hagan notes that at present the recovery literature is very “*monocultural*” (O’Hagan 2004), whilst Jones and colleagues found an absence of attention to race, culture and ethnicity in their review of the recovery literature (Jones 2007). A subgroup analysis of papers included in the systematic review cited earlier (Leamy et al. 2011) specifically considered individuals from non-majority populations. Only six of the 97 included papers focused on individuals from minority populations. Many of the themes identified in studies of minority populations paralleled those reported in the qualitative studies of Kartalova-O’Doherty and colleagues (this issue) and Todd and colleagues (this issue), as well as the findings from the overall systematic review. For example, recovery was not simply an absence of symptoms, but involved personal responsibility and empowerment, as well as connections with other people. However, despite the overall similarity, there were five main differences in respect to the perspectives on recovery of people from minority communities. These were: an increased emphasis on the role of spirituality and religion; additional stigma and discrimination faced by individuals and their families; culturally specific facilitating factors such as traditional healing practices; individualistic versus collectivist values and the impact that differing values have on the meaning and experience of recovery; and additional barriers at the level of the mental health system, including perceptions of institutional racism. These differences in the perception of recovery needs to be taken into account when designing a recovery orientated service, particularly if services are to meet the needs of individuals from a diverse range of backgrounds (Mental Health Providers Forum 2009).

‘Hope is necessary for recovery’

The study by Hobbs and Baker (this issue) into the relationship between hope and recovery identifies the mediating role of context and relationships, including with clinicians. Alongside the emerging evidence base for interventions to promote hope (Schrack et al. 2012) and its relationship with related experiences

such as compassion (Spandler and Stickley 2011), this kind of research will help identify the contribution that mental health services can - and cannot - make to recovery (Slade 2009). However, another axiom in the recovery approach is 'hope, without opportunity, dies'. Many people using mental health services do not access the normal experiences of citizenship. For example, impoverished social networks remain the norm (Forrester-Jones et al. 2012). One solution is the development of peer support worker services in health services. Peer support, whilst not without challenges (Scott, this issue), brings benefits at multiple levels, including for the employed person and the people using services with whom they work (Repper and Carter 2011). Work-force transformation towards a greater proportion of people with lived experience is one organisational change strategy being used in England to improve recovery support in mental health services (Perkins and Slade 2012).

'Mental health workers can help or hinder recovery'

The contribution of clinicians is explored by Hicks and colleagues (this issue), who investigate the relationship between alliance and recovery. The causal relationship between therapeutic alliance and clinical outcomes has been established (Junghan et al. 2007), and an important future research priority will be to understand the longitudinal relationship between alliance and recovery outcomes using multivariate repeated measures designs.

More generally, emerging best practice in supporting recovery is becoming clear. Although guidance on recovery orientated practice exists, there remains a lack of clarity regarding best practice (Lakeman 2010). An empirically-based recovery practice framework was developed to address this knowledge gap (Le Boutillier et al. 2011). The practice framework was developed following an inductive thematic analysis of 30 documents from six countries detailing international practice guidance on supporting recovery. Four overarching levels of practice emerged from the synthesis: promoting citizenship, organisational commitment, supporting personally defined recovery, and working relationship. The framework shows that citizenship can be promoted across the health system, so people with mental illness are supported to live as equal citizens. It also highlights that organisational support for recovery involves demonstrating that services are responsive to the needs of people living with mental illness and not primarily to the needs of services. It points to the importance of individual practitioners viewing recovery support as central to practice and not as an additional task, and forming partnership relationships where people accessing services are empowered to lead the intervention process and to shape their own future. The framework provides direction to individual professionals about supporting recovery in their own practice, and to services when considering implementation of a recovery orientation across the organisation. Although the understanding of recovery and recovery orientated practice is still developing, the framework shows that services and professionals can play a pivotal role in supporting the implementation of recovery orientated practice across all four practice domains.

Can recovery be scientifically investigated?

Recovery research involves new values and modified methodologies (Mond 2012). For example, relationships of trust are needed between scientific researchers and experts by experience (Slade et al. 2010). Such relationships evolve over time, and need to be based on genuine partnership in which the sometimes difficult issues of power imbalances are acknowledged. In practice, this means that efforts to cross-sectionally identify the degree of consumer involvement in say a grant proposal may inadvertently encourage tokenism, if lived experience 'partners' have a reduced role post-award.

Methodology may also need modification. For example, service users have concerns about some commonly-used outcome measures (Crawford et al. 2011), and new measures are being developed which more fully incorporate service user perspectives (Evans et al. 2012). In relation to support experienced for recovery from mental health services, a systematic review of measures that assess the recovery orientation of services found problems with all identified measures (Williams et al. in press). Four main weaknesses were identified. First, the conceptual underpinnings of the measures were diverse, making comparisons between them difficult. This diversity may reflect debates on how recovery should be defined. Second, measures differed in the aspects of services they assessed. Services can support recovery in many ways, so the specific aspects being assessed need to be very clear to the service user completing the measure. Third, most existing measures have had inadequate psychometric evaluation, so the validity, reliability and ability to measure change have not yet been demonstrated. The absence of adequate psychometric testing means that researchers and clinicians may not be confident to use these measures to evaluate interventions and inform practice. Finally, the conceptualisation of recovery and the structure of services will differ across cultures, which may mean that measures need to be developed specifically for a particular culture or country. None of the existing measures have been adequately tested outside their country of origin, so it is not known whether they can be used successfully in other cultures or countries. Cultural validity is becoming a research focus, for example in a recent review of recovery measures specifically for use in Australia (Burgess et al. 2011).

There remains a need for a quantitative measure of recovery support from mental health services. Potential uses of such a measure include informing individual clinical practice, benchmarking services, and providing a clinical end-point in randomised controlled trials (Slade et al. 2011). Given the absence of an adequate existing measure, a new measure has been developed to assesses how service users experience staff support recovery. The measure, called INSPIRE (downloadable from researchintorecovery.com/inspire), is rated by service users and conceptually based on the two reviews described earlier. It assesses the practice domains of supporting personally defined recovery and working relationships (Le Boutillier et al. 2011) through a 21-item Support sub-scale and an 8-item Relationships sub-scale, and covers the five CHIME recovery processes of connectedness, hope and optimism, identity, meaning and

purpose, and empowerment (Leamy et al. 2011). A key innovation to keep the values of the respondent central has been the incorporation of a utility rating. For each Support item, respondents identify whether it is important to them for their recovery or a domain that, whilst personally important, is not one for which they want help from services. Only if the domain is important and help is wanted does the service user rate the support from the worker, and the Support sub-scale score is calculated from these ratings only. In this way, and in common with other innovations in idiographic measurement (Wolpert, this issue), INSPIRE has the potential to be both standardised (psychometric evaluation is currently underway) and to reflect the values of the service user.

The future for recovery

A recovery approach challenges some previously incontestable clinical truths, such as 'treatment is needed for recovery' and 'recovery involves reduced symptomatology and improved functioning'. Hard-won wisdom developed from the narratives and insights of individuals with personal experience of mental illness (Andersen, this issue) are now the focus of empirical investigation. Ideological maturation requires this development. Some recovery axioms may not survive this scrutiny, and will come to be disregarded. Others will emerge as guiding principles for future mental health services and wider societies.

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